Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 07/06/01.
   b. The request was received on 05/20/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Request for Medical Dispute Resolution
   b. HCFAs-1500
   c. EOBs/ ALT TWCC 62
   d. Reimbursement data (EOBs from other carriers)
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:
   a. TWCC 60 and Response to the Request for Medical Dispute Resolution
   b. HCFAs-1500
   c. EOBs/ ALT TWCC 62
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the request on 07/15/02. The Respondent did not submit a response to the request. The "No Additional Information Received" sheet is reflected in Exhibit II of the Commission's case file. The carrier's initial response, date stamped 06/14/02, is included in the case file and will be reviewed.

4. Notice of A Copy of a Requesting for Medical Dispute Resolution is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/15/02
   "The disputed issue is that the Carrier has paid $610.30 for these products stating no MAR reduced to fair and reasonable. We resubmitted the claims the Carrier requesting additional payment. The Carrier denied the request…."

2. Respondent: 06/14/02
"…I am filing the TWCC-60 Form on behalf of the above referenced insurance carrier in response to the Requestor's dispute regarding fee reimbursement for date of service 07-06-01 in the amount of $114.60….The amount rendered is equal or exceeds the payment… for medical providers."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/06/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $724.90; the amount paid is $610.30; the amount in dispute is $114.60.

3. The carrier's EOB denials submitted are "F – Reduced According to the Fee Guideline"; F,375 - 375 PLEASE SEE SPECIAL NOTE* BELOW. *M – Reduced to Fair and Reasonable; *M,426-REDUCED TO FAIR AND REASONABLE.; *360 – ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE 'FAIR AND REASONABLE' AMOUNT FOR THIS GEOGRAPHICAL AREA."

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
07/06/01 for all codes	E1399 Betadine Swabs 3/pk E1399 Wound Closure Air Strips 3x10 E1399 Wound Dress Primapore 11.75 x4	$9.60 $126.90 $83.40	$2.76 $107.86 $70.89	F,M375 M426 M,F426	DOP all codes	TWCC Act & Rules Sec. 413.011 (d), Rules; 133.304 (i) & 133.307 (3)(g)(D); DME GR (VIII)	The provider included in their dispute packet, documentation (EOBs from other carriers) that does provide some evidence of "fair and reasonable" reimbursement. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence of fair and reasonable. The carrier responded to the dispute, but did not submit any evidence or methodology used to determine to support the amount reimbursed a fair and reasonable amount. The provider submitted EOB's that do show some evidence of fair and reasonable. Therefore, based on the documentation submitted, additional reimbursement is recommended in the amount of **$114.60**

	E1399 Nugauze 4x4 2pk L0565 Custom Fitted Body Jacket	$10.00 $495.00	$8.04 $420.75	F M,426, 360			
Totals		$724.90	$610.30				The Requestor **is** entitled to additional reimbursement in the amount of **$114.60**.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $114.60 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 24th day of February 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm